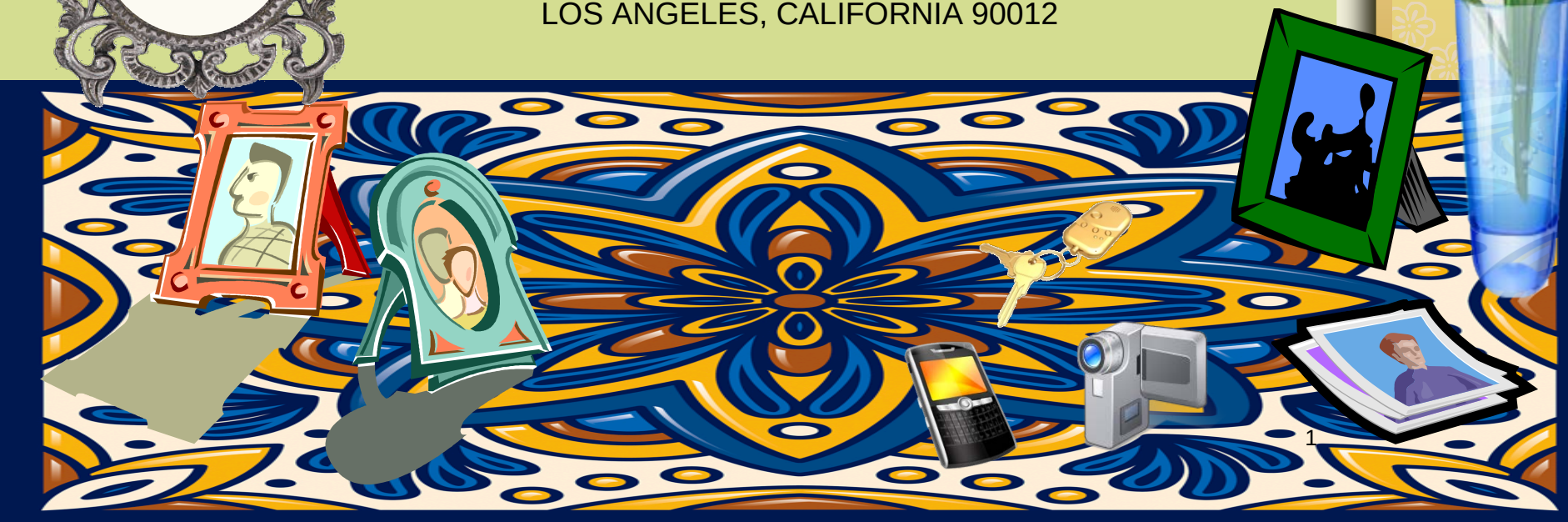
7th Annual Housing Institute

"HEALTH COMES HOME..."

Building Community and Better Lives

June 10 – 11, 2014
CALIFORNIA ENDOWMENT
1000 ALAMEDA STREET
LOS ANGELES, CALIFORNIA 90012



HOW TO DOCUMENT
&
CLAIM FOR HOUSING SERVICES

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Program Support Bureau
Quality Assurance Division

IMPORTANCE OF QUALITY DOCUMENTATION

- Supports quality of care by:
  - Keeping services focused on client goals
  - Coordinating client care within and between service providers
- Supports financial needs of clients by demonstrating initial and continuing eligibility for benefits
- Supports revenue generation by:
  - Documenting to Medi-Cal/Medicare requirements
  - Providing audit protection
- Supports the Department when ethical/legal issues arise around service delivery (Risk Management)

THE CLINICAL LOOP

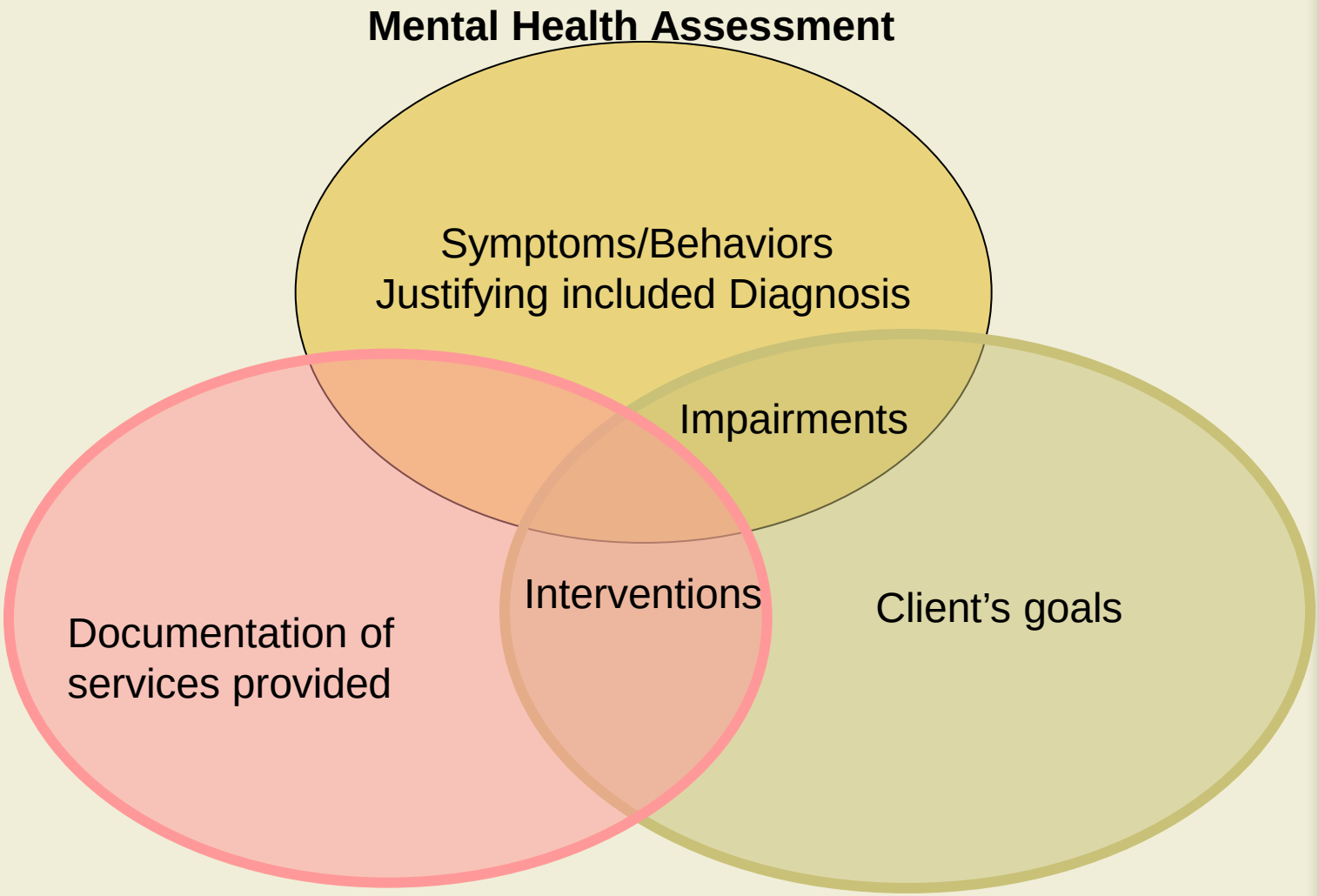
- The “Clinical Loop” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are Medi-Cal reimbursable

- **Making sure everything is linked to the Diagnosis--- from the Assessment to the Treatment Plan (TX Plan) to the Progress Notes**

THE CLINICAL LOOP

- Step One - Completion of a Mental Health Assessment including:
  - Symptoms/Behaviors leading to Included Diagnosis
  - Impairments, Needs, and Strengths
- Step Two - Carry forward into the TX Plan and document:
  - Goals linked to Symptoms/Behaviors
  - Interventions to effect impairments
- Step Three - Carry forward into the Progress Note which documents:
  - Goal-based interventions provided to client

CLINICAL LOOP



TARGETED CASE MANAGEMENT-DEFINITION

- **Definition:** Services needed to access medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services.
  - These services provide for the continuity of care within the mental health system and between the mental health system and related social service systems.

- **Code: T1017**

- **Claimable Activities to the extent they are related to functional impairments identified in the Assessment and articulated as goals on the TX Plan:**
  - Communication
  - Coordination
  - Referrals
  - Placement
  - Monitoring service delivery to ensure client's access
  - Monitoring/evaluating client's progress toward TCM goals
  - Plan development specific to TCM

SD/MC Organizational Provider's Manual – page 2-14
Guide to Procedure Codes – page 10

TARGETED CASE MANAGEMENT: LINKAGE & CONSULTATION

- **Code: T1017**
- **Claimable Activities to the extent they are related to functional impairments identified in the Assessment and must be linked to goals on the TX Plan:**

Linkage and Consultation - The identification and pursuit of resources including, but not limited to, the following:

- **Interagency and intra-agency consultation, communication, coordination, and referral**
- **Monitoring service delivery to ensure a client's access to service and the service delivery system**
- **Monitoring of the client's progress**

Plan Development – is defined as a service activity which consist of development of TX Plans, approval of client plans and/or monitoring of a client's progress

SD/MC Organizational Provider's Manual – page 2-14
Guide to Procedure Codes – page 10

TARGETED CASE MANAGEMENT- PLACEMENT

- **Code: T1017**
- **Placement Services must be articulated as goals on the TX Plan:**

Placement Services – Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including, but not limited to the following:

- **Monitoring of the client's progress**
- **Locating and securing an appropriate living environment**
- **Locating and securing funding**
- **Pre-placement visit(s)**
- **Negotiation of housing or placement contracts**
- **Placement and placement follow-up**
- **Accessing services necessary to secure placement**

SD/MC Organizational Provider's Manual – page 2-14
Guide to Procedure Codes – page 10

PLAN DEVELOPMENT

- **Types of Plan Development:**
  - Plan development activities often occur in the context of a client/collateral contact with the time required to write up the Plan included as part of documentation time for that contact/Procedure Code
  - When plan development occurs in the context of a team conference or consultation where the service provided is directed towards staff or other agencies instead of the client/collateral(s), it should be claimed as:
    - **Team Conference/Case Consultation- H0032**
  - When plan development occurs in the context of targeted case management, i.e. linking client to needed community resources, it should be claimed as:
    - **Targeted Case Management- T1017**
  - When plan development occurs in the context of medication support services, i.e. plans regarding a client's medications, it should be claimed as:
    - **Medication Support Service**

TARGETED CASE MANAGEMENT (TCM)

- **Points to Remember:**
  - Linkage and referral activities must be related to functional impairments identified in the Assessment and the TX Plan
  - Transporting a client implies staff is simply providing transportation which is not a TCM claimable activity. **NOTE**: Can claim if providing a service while taking a client to destination.
  - Related TCM activities provided by the same Rendering Provider within a day, such as several phone calls to locate an appropriate placement for a client, may be combined into a single note and submitted as one claim

TARGETED CASE MANAGEMENT (TCM)

- **Example of Reimbursable Services:**
  - Following up with client or the provider about the outcome of a referral
  - Making a referral or calling providers of needed services to determine availability
  - Assisting clients to understand the requirements of participation in a program in order to make appropriate linkages
  - Coordinating with a service provider to help client to maintain a service
  - Developing strategies with client for accessing Senior Center activities **(For example: in the housing complex or in the community)**
  - Assisting a client with the completion of forms related to seeking services **(For example: for housing)**

MENTAL HEALTH SERVICES
Individual Rehabilitation

- **Definition:** Service to provide assistance in improving, maintaining, or restoring the client's:
- ***Functional skills***
- ***Meal preparation skills***
- ***Daily living skills***
- ***Grooming & personal hygiene skills***
- ***Social & leisure skills***
- ***Support resources***

- **Code: H2015.**

- **Points to Remember:**
  - Rehabilitation involves working **WITH** a client to overcome impairments blocking the building of skills; it is **NOT** teaching a skill or performing functions for a client
  - The contact could include family or other collaterals and/or significant support persons

Guide to Procedure Codes – page 5

MENTAL HEALTH SERVICES
Individual Rehabilitation

- Working with a client to develop skills that maintain and/or restore optimal functioning
- Providing education/training to assist the client achieve his/her personal goals in such areas as daily living skills, socializations, mood stabilization, resources utilization, and medication compliance
- **Assistance to assess housing needs and to obtain and maintain a satisfactory living arrangement**

MENTAL HEALTH SERVICE
Group Rehabilitation

- **Definition**: Service delivered to more than one client at the same time to provide assistance in improving, maintaining, or restoring his/her support resources or his/her functional skills – daily living, social and leisure, grooming and processional hygiene, or meal preparation.

- **Code: H2015**

- **Points of Remember:**
- Licensed staff should use this code any time they are delivering group rehabilitation services
- When licensed and unlicensed staff co-lead a group , this code must be used.
- This code could be used for a didactic substance abuse education group, ADL, or any other educational group in which there is not a therapeutic, inter-personal interaction.

MENTAL HEALTH SERVICES
Collateral

- **Definition:** Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, (age eighteen (18) and above) advising them on how to assist the client, obtaining information from collaterals regarding the client
- **Code: 90887**
- **Points to Remember:**
  - Contacts are not necessarily face-to-face
  - Client may or may not be present
  - Service must be a direct benefit to the client and not the collateral

MENTAL HEALTH SERVICES
Collateral vs. Team Conf/Case Consult

- **The distinction is in who the service is directed toward, but its always for the benefit of the client:**
  - **Collateral** services involve interactions with persons such as a parent, foster parent, spouse, partner, legal guardian, non-paid conservator
  - **Team Conference/Case Consultation** involves interactions with intra-agency or inter-agency mental health treatment team members, non-mental health agency staff, school teachers, board and care operators, paid conservators

MENTAL HEALTH SERVICES
Team Conference/Case Consultation

- **Definition:** Interdisciplinary inter/intra-agency conferences to coordinate activities of client care.
- Client may or may not be present and it must be about plan development.
- Note: *Consultants are being paid to be in the client's life.*
- **Use only if you need special expertise on issues that clinician/case manager is not fully trained on or no knowledge or specialization regarding that specific condition.**
- **Codes: HOO32**

Guide to Procedure Codes – page 10

MENTAL HEALTH SERVICES
Team Conference/Case Consultation

- **Points to Remember:**
  - Supervision time is not reimbursable
  - Claim only the actual time a staff person contributed to the conference **(listening and learning are not included)** and any other time a staff person spent related to the conference, such as travel or documentation.
  - **If the client is present and involved in the plan development, there is must be face-to-face time associated with the plan development claim**.
  - **The threshold for most programs is 180 minutes per client/per quarter *if there is no face-to-face contact*. Some specialized programs have requested and received approval for a threshold of 360 minutes**.

REIMBURSABLE

&

NON-REIMBURSABLE SERVICES

REIMBURSABLE SERVICES

- Make sure the impairments are documented in the Assessment, TX Plan-intervention, and Progress Note to support the client's DX/ impairment which is hindering them from completing the forms)

- Assists with completion of applications for rental subsidies such as Section 8 and Shelter Plus Care, housing programs or private rental agreements **(H2015 use as a Individual. Rehab.)**

- Assists clients with accessing and maintaining housing resources. **(H2015)**

- Accompanies/transports the consumer to all necessary related appointments as requested **(H2015 Must link to DX and/or mental status – for example, Client has Anxieties about riding the Bus)**

REIMBURSABLE SERVICES

- Assists with preparing for interviews with Housing Authority, managers and property owners (e.g. mock interviews) **(H2015 use as a skill building)**

- Educates individuals about tenant rights and responsibilities **(H2015)** Use as a skill building due to client's behavior/ impairments that cause them to have difficulty understanding rules and regulations)

- Liaison between landlord and consumer and mental health team **(H0032)** or:
- ***if a collateral is involved then use 90887*** advising them on how to assist the client, obtaining information from collaterals regarding the client mental illness)

- Treatment team member with expertise in housing issues. **(H0032)**

REIMBURSABLE SERVICES

- Informs team of any observed or landlord/manager reported difficulties consumer is experiencing in the housing including the need for additional supports, crisis intervention or medication evaluation

- **(H0032)—**Make sure that the Housing Specialist has the impairments from the Team Member and that it is documented in the Assessment, TX plan, and Progress Notes

- **Accepts housing assistance referrals from team members <u>during</u> Team Conference/Case Consultation (H0032)—**Make sure that the Housing Specialist has the impairments from the Team Member and that it is documented in the Assessment, TX plan, and Progress Notes

- **NOTE: <u>Make sure that there is a plan in place and it is documented in the Progress Note.</u>**

- Keeps team informed of consumer progress in meeting housing goals **(H0032)—**Make sure that the Housing Specialist is on the **intervention of the Team Member's goals** and that it is documented in the Assessment, TX plan, and Progress Notes

REIMBURSABLE SERVICES

- Provides referrals to appropriate housing resources **(T1017)**
- Assists in the housing search process **(T1017)** use as a skill building for ex. Client is organizing a list of homes and areas of stable living environment
- Ensures consumer is connected to on-going mental health supports **(T1017--linkage)**
- Liaison between client and manager to avert possible eviction **(T1017)**
- **Referrals from interagency and intra-agency re: placement (T1017)—how and where to find housing that is appropriate.**
- Advocates for clients with landlords when tenant's rights have been violated. **(T1017)**

NON-REIMBURSABLE SERVICES

- Identifies and develops housing resources.
- Assists in resolving legal history barriers (e.g. warrants, expungement)
- Gathers required documents such as identification, social security card, bank statements
- Determines and certifies eligibility for federal, state and locally funded housing programs by verifying income, assets and other financial data
- Assists with compiling and assessing eligibility information in compliance with housing regulations
- Advocates and negotiates for clients with poor credit and poor housing histories (i.e. evictions or lack of housing tenancy)
- Assists with move in

NON-REIMBURSABLE SERVICES

- Provides information and assistance to team members regarding the housing resources in the community including temporary, transitional and permanent housing
- Researches housing resources and develops community specific housing resource directory
- Liaison to Countywide Housing, Employment and Education Resource Development (CHEERD)
- Represents agency/program at Service Area and County-wide housing related meetings
- Averts possible evictions by maintaining professional relationships with property owners and managers and promptly addressing their concerns
- **DO NOT CLAIM FOR SUBSTITUTE PAYEE FUNCTION UNDER MONEY MANAGEMENT.**

COS---BILLING

- Provide education about mental health to reduce the stigma associated with mental illness.
- **This code is used for: <u>NON-OPEN CASES. PLEASE CHECK YOUR CONTRACT WITH YOUR SUPERVISIOR, PROGRAM MANAGER, OR DISTRICT CHIEF.</u>**

- **CODE: 200**
- Example: Educate consumers or community agencies/organizations about available housing resources and assistance for consumers with Mental Disorder.

Client Treatment Plan(IBHIS)

- **OLD Policy**
- CCCP must be completed within 2 months (1 month if opened elsewhere).
- Best practice: prior to treatment services being provided.

- **NEW Policy**
- **The name CCCP will be replace by Treatment Plan (TX Plan)**
- If emergent treatment services are needed prior to the completion of the assessment, a written plan must be in the progress note.
- Completing the Treatment Plan is considered a **"Plan Development"** activity

Client Treatment Plan(IBHIS)

- **OLD Policy**
- CCCP must be completed annually prior to the cycle date
- Annual cycle month=month of admission
- Admission on 1/25/13;
- Cycle date is 1/1/14;
- Annual CCCP due by 12/31/13
- May be additional review periods based on the type of service

- **NEW Policy**
- For active clients, a Client Treatment Plan must minimally be completed with the client once every 365 days
- Treatment Plan done on 1/25/13 then the Annual Client Treatment Plan due by 1/25/14
- If client is unavailable, must be completed at the point of next service with the client.

Client Treatment Plan(IBHIS)

- **OLD Policy**
- CCCP must be completed by each program providing services.

- **NEW Policy**
- The Client Treatment Plan must be completed in each Clinical Record.
- Providers using the same Clinical Record may share a Client Treatment Plan.

Client Treatment Plan(IBHIS)

NEW Policy

- A formal Coordination Plan is no longer required
- Staff and Providers must still coordinate the care of clients
- You have 2 options:

Update

- When you are updating the TX Plan it **does not restart** the “365” day clock

Annual

- When you are writing either an initial Treatment Plan or a new Treatment Plan
- **NOTE**: Selecting this **“restarts”** the 365 day clock

EXAMPLE

If a client is being seen by 2 different providers, THE Primary Contact at the Primary Program of Service writes the initial Client Treatment Plan (i.e. Plan Author) in the clinical record and the other provider adds their Objective/Interventions to that same Client Treatment Plan as an Update.

Treatment Plan

- Must have a goal/objective for every type of service provided
  - Mental Health Services, Medication Support and Targeted Case Management; Day Treatment and Day Rehabilitation; Residential
  - **Only emergency services are not required to be on the Treatment Plan**
  - For new clients, TX PLAN must be completed within 60 days of admission and annually or when a new objective is added.
  - **A treatment plan needs to be written as soon as a MHS service is provided.**
- Goals must be directed towards the individual client
- Goals should be linked to symptoms/behaviors/ impairments in Assessment
- Interventions should focus primarily on symptom reduction to improve functional impairments documented in the Assessment

Examples of Goals

- To decrease Anxiety **(For example: client has difficulty being around people):**

  Identify strengths that can assist client to develop a plan to cope with anxiety-Client will attend social skills group therapy 1x a week for 6 months.

- To manage stress and anxiety in client's living environment:

  Client will learn money management skills to increase awareness of maintain stable housing—Client will attend Money Management Group 2x a week for 6 months.

Examples of TCM Documentation

- Example: CM assisted client in completing the Section 8 application. Client is paranoid and states, “Too many pieces of paper to complete, I can’t do it.” Client would not be able to complete Section 8 paperwork without the assistance of CM.

- Example: CM researched for available and affordable housing for client via internet and also researched other resource guides. CM obtained information on several affordable apartments and contact information to give to client. CM will assist client to set up a pre-placement apartment visit.

Case Example

- Ken is a 84 years old male who is about to be homeless, due to not paying his rent on time and he is a hoarder with 4 dogs living with him. He also is surrounded by dog feces. Ken hears voices telling him to wait for the spaceship to come and retrieve him. Ken has religious delusions and believes he is God and will save the world. He also has not been to the doctor since his psychiatric hospital discharge, due to being gravely disable, danger to himself and others. Ken is disheveled and has not showered for over 2 months. He also has gout (infected right large toe) with open sores. His diet is composed of dog food and water.

- Ken's strengths are that he loves his dogs and he has family and friends that are willing to help him.

Ken is a 84 years old male who is Undifferentiated Schizophrenia and Gout.

Symptoms:

1. Poor Diet
2. Isolated/withdrawn from family/friends
3. Auditory Hallucinations
4. Grandiose delusions
5. Poor ADLs
6. Hoarder

- Does client meet Medical Necessity?
- What are the main Mental Health Issues?
- What are the Health Issues?
- What Type of Services will she need?

A) HOW DO WE FORMULATE THIS PLAN?

- Axis I- Undifferentiated Schizophrenia
- Secondary-
- Axis III- Gout (Right large infected toe)

B) CLIENT WILL NEED WHAT TYPE OF SERVICES?

- **MENTAL HEALTH SERVICES (MHS)** (INDIVIDUAL/GROUP THERAPY)
- **MEDICATION SUPPORT SERVICES (MSS)**
- **TCM (T1017)**

C) GOALS/Objectives

- **GOAL # 1 (MHS)** Client decrease auditory hallucinations 2x a day to 0x a day within 6 months. Social worker will have Individual therapy 2x week at client's home (home visits)
- **GOAL # 2 (MSS)** Client will take Antipsychotics meds from 0x/day to 2x/day within 6 months.
- **GOAL # 3 (TCM) Client will be linked to community services regarding his housing and government assistance for food and benefits 0x a month to 4x a month within 6 months**

NOTE: work on possible conservatorship with family/friends

Ken's Interventions

Goals/Objectives

- **GOAL # 1 (MHS)** Client decrease auditory hallucinations 2x a day to 0x a day within 6 months.
- **GOAL # 2 (MSS)** Client will take Antipsychotics meds from 0x/day to 2x/day within 6 months..
- **GOAL # 3 (TCM) Client will explore community services regarding his housing and government assistance for food and benefits 0x a month to 4x a month within 6 months**
- **NOTE: Work on possible conservatorship with family/friends**

Interventions

- **MHS-**Client will attend **individual and Group therapy 1x a week (SW--HOME VISITS)** to identify recent maladaptive behaviors or situations in the client's life and discuss how health issues may contribute to mental health problems
- **MSS**

1. Medication Education and Medication Management **2x per month**. Nursing staff will monitor client's medications and dressing change.

2.Discuss techniques of self-care and self-management **1x weekly**

3. Will evaluate for psychotropic medications will assess client for continue medication as prescribed (EX. Topamax 50mg PO TID) **1x a month**

- **TCM- CM will link client to Meals on Wheels and Adult Day Care Program from 0x to 5x a week**
- **TCM-CM will link client to a board and care placement/housing within 3 months**

PROGRESS NOTES

- **Minimum Requirements:**
  - All clinical interventions must be included in the progress notes and must be consistent with the client's goals/desired results identified in the TX Plan
  - Date (month/day/year) of service
  - Type (Meds, CI, TCM) or, for MHS, subtype (Ind, Gr, Col, etc) of service delivered
    - For groups, the number of clients for which a claim will be submitted
  - Location of service
  - Signature of service provider
  - Full name, Professional License/Job title

PROGRESS NOTES

Points to Remember:

- Make sure you document the intervention.
- Make sure you have signatures, legible writing, functional impairments/ skill building activity related to the impairments and it is all documented in the Assessment, TX Plan, and the Progress Notes.
- **Progress Notes need to be <u>Clear and Concise</u>**
- Make sure you document and identify interventions of other staff that are participating.
- Make sure you are billing the right billing code for the right services (example of services that are not billed correctly: documented TCM but claimed MHS)

Resources

- QA Resources can be found on-line at: http://dmh.lacounty.gov
  - Under: “For Providers”
- For QA Manuals and training documents:
  - Click on: “Provider Manuals and Directories”
  - http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals
- For Clinical Forms:
  - Click on: “Clinical Forms”
  - http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_forms
- For Administrative Forms:
  - Click on: “Administrative Forms”
  - http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/admin_forms

QUESTIONS . . .

THANK YOU FOR YOUR PARTICIPATION!!!

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